TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
BAYLOR SURGICAL HOSPITAL AT TROPHY CLUB

Respondent Name
GREAT AMERICAN ALLIANCE INSURANCE COMPANY

MFDR Tracking Number
M4-18-0280-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 3, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are requesting 130% of the Medicare allowable with implant reimbursement."

Amount in Dispute: $4,579.70

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the carrier's position currently is that the carrier's initial EOB dated August 4, 2017 and which recommended reimbursement of $7,923.64 is correct."

Response Submitted by: Flahive, Odgen & Latson, Attorneys At Law, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
May 23, 2017	Outpatient Hospital Services	$4,579.70	$4,579.70

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes (issued prior to the filing of the request for medical fee dispute resolution):
   - 353 – THIS CHARGE WAS REVIEWED PER THE ATTACHED INVOICE.
   - 370 – THE HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP.
   - 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED LEGISLATED FEE ARRANGEMENT.
   - 617 – THIS ITEM OR SERVICE IS NOT COVERED OR PAYABLE UNDER THE MEDICARE OUTPATIENT FEE SCHEDULE.
   - 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.

- 95 – PLAN PROCEDURES NOT FOLLOWED.
- 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
- P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- PHO – SURGICAL IMPLANT CHARGES REVIEWED SEPARATELY BY FORESIGHT MEDICAL. PLEASE DIRECT INQUIRIES FOR SURGICAL IMPLANT CHARGES TO 855-481-1205.
- U03 – THE BILLED SERVICE WAS REVIEWED BY UR AND AUTHORIZED.

Issues

1. What is the recommended payment for the services in dispute?
2. What is the additional recommended payment for the implantable items in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards outpatient hospital facility services with payment subject to 28 Texas Administrative Code §134.403, requiring the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount applying the effective Medicare Outpatient Prospective Payment System (OPPS) formula and factors, published annually in the Federal Register, with modifications as set forth in the rule. Medicare OPPS formulas and factors are available from the Centers for Medicare and Medicaid Services (CMS) at http://www.cms.gov.

   Rule §134.403(f)(1) requires that the sum of the Medicare facility specific amount and any applicable outlier payment be multiplied by 200 percent, unless a facility or surgical implant provider requests separate payment of implantables. Review of the submitted information finds that the provider requested separate payment for implantables; therefore, per Rule §134.403(f)(1)(B), the facility specific amount (including outlier payments) is multiplied by 130 percent. Per §134.403(f)(2), when calculating outlier payment amounts, the facility's total billed charges are reduced by the facility's billed charges for any item reimbursed separately under §134.403(g). The facility charges for the separately reimbursed implantables total $5,272.00. Accordingly, the facility's billed charges shall be reduced by this amount when calculating any outlier payments below.

   Medicare's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) to billed services based on procedure code and supporting documentation. The APC determines the payment rate. Payment for ancillary items and services is packaged into the APC payment. CMS publishes quarterly APC rate updates, available at www.cms.gov.

   Reimbursement for the disputed services is calculated as follows:

   - Procedure codes C1713 and C1762 represent the implantable items billed and have status indicator N, denoting packaged codes integral to the total service package with no separate payment; under Medicare payment policies, reimbursement for these codes is included in the payment for the primary services. However, division rules supersede Medicare payment policies, and when the provider requests separate reimbursement of implantables, separate payment is allowed in accordance with division guidelines. Per §134.403(f)(2), the facility's billed charges are reduced by the charges for any separately reimbursed implantables. The charges for the separately paid implantables total $5,272.00. The facility's total billed charges will be reduced by this amount when calculating any outlier payments below.
   - Procedure code C1762 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
   - Procedure code 23120 has status indicator J1, denoting packaged services paid at a comprehensive rate. All covered services on the bill are packaged with the primary J1 procedure. When multiple designated J1 procedures are performed together, only the highest-ranking J1 status procedure is paid. However, when the specific combination of comprehensive HCPCS codes with J1 status is eligible for complexity adjustment according to Medicare OPPS Addendum J, then the highest-ranking J1 procedure is paid at the next higher APC rate. This procedure is *not* the primary J1 service on this bill; payment for this code is packaged with J1 status code 23550, below.

- Procedure code 23550 has status indicator J1, denoting packaged services paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure (except those with status indicator F, G, H, L or U; certain inpatient and preventive services; ambulance and mammography). This code is usually assigned APC 5114. However, when multiple designated j1 procedures are performed together, only the highest-ranking J1 procedure is paid. If a pair of J1 codes is eligible for complexity adjustment, the highest-ranking J1 procedure is paid at the next higher APC rate. This procedure is the primary J1 service on this bill. Per Medicare OPPS Addendum J, the complexity-adjusted APC assignment is 5115, which has an OPPS Addendum A rate of $9,561.23. This is multiplied by 60% for an unadjusted labor-related amount of $5,736.74, which is in turn multiplied by the facility wage index of 0.9794 for an adjusted labor amount of $5,618.56. The non-labor related portion is 40% of the APC rate, or $3,824.49. The sum of the labor and non-labor portions is $9,443.05. Per 42 Code of Federal Regulations §419.43(d) and *Medicare Claims Processing Manual,* CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the fixed-dollar threshold of $3,825, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.298. This ratio is multiplied by the billed charge of $3,277.00 for a cost of $976.55. Next, the total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. Note that the charges for separately paid implantables are deducted from the bill's charges when calculating outlier payments. There is only one composite service paid on the claim; therefore, all costs are allocated proportionately to this line at 100.00%. The sum of packaged costs is $5,550.89, which is added to the service cost, for a total cost of $6,527.44. The cost of services exceeds the fixed-dollar threshold of $3,825; however, the cost does not exceed the multiplier threshold of 1.75 times the OPPS payment amount. Thus, the outlier payment is $0.00. The total Medicare facility specific amount of $9,443.05 is multiplied by 130% for a MAR of $12,275.97.
- Procedure code 64415 has status indicator T. Reimbursement for status T codes is included in the payment for comprehensive J1 procedure code 23550 billed on the same claim. Separate payment is not recommended.
- Procedure codes J0131, J1100, J1170, J2250, J2405, J2795, and J3010 have status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.

2. Additionally, the provider requested separate reimbursement of implantables. Per Rule §134.403(g):

> Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission.

Review of the submitted documentation finds the following implantables:

- "C1713 - KIT REPAIR AC TWIN TAIL" as identified in the itemized statement and labeled on the invoice as "AC TIGHTROPE, TWIN TAIL" with a cost per unit of $822.00;
- "C1713 - INSERTER BTN FOR PECTORA" as identified in the itemized statement and labeled on the invoice as "BUTTON INSERTER" with a cost per unit of $200.00;
- "C1762 - ACELLULAR TISSUE-LIQUID" as identified in the itemized statement and labeled on the invoice as "Paligen Flow Large 1.00 ml" with a cost per unit of $4,250.00.

Note that Rule §134.403(b)(2) defines "implantable" to mean an object or device that is surgically (a) implanted, (b) embedded, (c) inserted, (d) or otherwise applied, and (e) related equipment necessary to operate, program and recharge the implantable.

Documentation identifies the item billed under code C1762 as an allograft (human tissue from someone other than the patient). Medicare defines certain items as "devices" when used for specific functions. This item was billed using HCPCS C1762 (Connective tissue, human). This code is listed among Medicare's current List of Device Category HCPCS Codes. Medicare defines C1762 as tissues including "a natural, cellular collagen or extracellular matrix obtained from autologous rectus fascia, decellularized cadaveric fascia lata, or decellularized dermal tissue. They are intended to repair or support damaged or inadequate soft tissue."

While, ordinarily, liquids are not "objects" consistent with the division's definition of an implantable, they may still qualify as implantables if used as a "device." The operative report supports that this tissue was placed around the ligaments as an adhesion barrier, and to promote soft tissue and ligament healing. The medical documentation supports the intended function was to repair and support damaged or inadequate soft tissue. The use of this tissue is therefore consistent with Medicare's definition of the device code.

Consequently, the division finds this item meets the definition of an implanted "device" under Rule §134.403(b)(2) and is eligible for separate reimbursement as an implantable.

Documentation from the insurance carrier's medical bill auditor, ForeSight, argues that:

> While the provider did submit a certification statement with the MFD Request, ForeSight believes no further allowance for implants is due because C1762 is not payable as it has a status indicator of "N."

This argument, however, is not supported.

The division notes that Medicare does not normally pay for surgically implanted devices. In fact, *most* Medicare codes for devices and implantable items have status indicators of "N," and so are considered *bundled* under Medicare payment policy. And bundling would indeed be appropriate if the health care provider had requested reimbursement at the higher payment adjustment factor (PAF)—without separate reimbursement of implantables. Per Medicare payment policies, the implantable items would then have been bundled with payment for the primary services — if the primary services were paid at the higher PAF.

However, when a provider requests separate reimbursement of implantables, division rules supersede Medicare payment policies. Rule §134.403(d) states that [*emphasis added below*]:

(d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided **with any additions or exceptions specified in this section**, including the following paragraphs.

(1) **Specific provisions** contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, **shall take precedence over any conflicting provision adopted or utilized by the CMS in administering the Medicare program**.

As division rules concerning separate payment of implantables are provisions that *take precedence over any conflicting provision adopted or utilized by the CMS in administering the Medicare program*, Medicare's payment status indicator of "N" (or other bundled status)—with regard to any code used to bill an implantable item—*is not relevant* in determining separate payment for implantables *when separate reimbursement has been requested* by the provider in accordance with Rules §134.403(f)(1)(B) and §134.403(g).

The division has stated in the preamble to the *Hospital Facility Fee Guideline—Outpatient* (Rule §134.403):

> Medicare's methodology does not include a separate reimbursement for surgically implanted devices . . . These fee guidelines adopt separate reimbursement for surgically implanted devices in order to ensure injured employees have access to quality medical care, including surgery where surgically implanted devices are medically necessary. . . . Hospitals will have the option to choose the higher or lower PAF for each guideline. The higher PAF contemplates the inclusion of reimbursement for surgically implanted devices . . . If the hospital chooses the lower PAF, the surgically implanted device(s) will be reimbursed separately at cost plus an administrative expense fee. (33 *Texas Register* 406)

The division stated further, "Although implantables can be reimbursed separately, the payment adjustment factor has been reduced to offset the separate reimbursement." (33 *Texas Register* 414)
The division also explained, "facilities have a choice of reimbursement options relative to implantable devices, which insulate facilities from potential losses due to extremely expensive implantables whose costs may not be fully realized in the Medicare prospective payment system." (33 *Texas Register* 422)

Accordingly, the insurance carrier has failed to support its argument that implantable items with Medicare payment status code "N" are not payable when separate reimbursement of implantables has been requested. Division fee guidelines and the preamble to the hospital fee guidelines make clear that "The hospital has the option to be paid at the higher payment adjustment factor or be reimbursed at the lower rate and recover actual costs for the implantable device." (33 *Texas Register* 422)

The division therefore concludes that the provider has met the requirements for separate reimbursement of the above implantable items. Reimbursement for the implantables is recommended as follows:

The total net invoice amount (exclusive of rebates and discounts) is $5,272.00. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $527.20. The total recommended reimbursement amount for the implantable items is $5,799.20.

3. The MAR for the disputed services is $12,275.97. The recommended reimbursement for the separately paid implantables is $5,799.20, for a total recommended reimbursement—for all disputed services and items—of $18,075.17. The insurance carrier has paid $7,923.64. The requestor is seeking additional reimbursement of $4,579.70. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the findings and decision in this dispute are based on the available evidence presented by the requestor and respondent at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $4,579.70.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $4,579.70, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	December 8, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (form DWC045M) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.